# MEDICAID

MONTANA MEDICAID PRIOR AUTHORIZATION REQUEST FORM

DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES (Rev., Jul 99)

| PATIENT NAME, ADDRESS, TELEPHONE NUMBER, DATE OF BIRTH<br><br>MEDICAID I.D. NUMBER: | SUPPLIER NAME, ADDRESS, TELEPHONE NUMBER<br><br>MEDICAID PROVIDER NUMBER: |
|---|---|
| OTHER INSURANCE: | PHYSICIAN NAME, ADDRESS, TELEPHONE NUMBER |

RESIDENCE: (CIRCLE ONE) Home, Nursing Home, Hospital Rehab Unit, Group Home, Other:_____

1. Does the patient have the ability to operate/use this requested item as intended by the items manufacture?: Y / N

2. Has the patient received a trial use of this item: Y / N

If yes, for how long: _____ Was the item billed to Medicaid as a rental during the trial use period?: Y / N

3. Is the product or its components covered by a warranty? Y / N

If yes, attach warranty information.

## SPECIFICATION LIST

*NOTE: ALL BILLABLE ITEMS THAT MAKE UP THIS REQUEST MUST BE LISTED INDIVIDUALLY BELOW. ANY ITEM THAT IS NOT LISTED BELOW IS SUBJECT TO RECOVERY IF ADDED AND BILLED TO MEDICAID AT A LATER TIME.* (If additional space is needed, a continued sheet can be attached to this document as long as the pertinent patient and supplier information is included at the top of the attachment.)

| DOS | LEVEL II CODE | DESCRIPTION | MANUFACTURE | PRODUCT # | UNITS | LIST PRICE | DEPT. USE ONLY: |
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I certify that the information contained in this document and its attachments/supporting documents are true, accurate and complete, to the best of my knowledge. I further certify that all measurements, fitting, assembly and adjustments have been completed, or will be completed upon delivery. I understand my responsibility to train the client and/or caregiver in the proper use and advise any safety issues of the requested item. I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.

SUPPLIER SIGNATURE: _____ DATE ___/___/___ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

**Attachments:** This form must be accompanied by copies of supporting documentation to justify the medical need of the requested items. Supporting documentation includes, but is not limited to a prescription, Certificate of Medical Need (if required of the item), and a narrative description detailing the need for the item from the patients primary care provider. If client is being treated by a licensed therapist, a copy of the clients plan of care and a narrative summary supporting this request is required.

MONTANA
Department of Public Health & Human Services